

EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE

A Joint Statement by Doctors and Lawyers

1. Introduction

Euthanasia is the deliberate act of putting an end to a patient's life for the purpose of ending the patient's suffering. Physician Assisted Suicide (PAS) is the death of a patient as a direct consequence of 'help' by a doctor. (For a definition of terms used, please see the end of this document.) Whatever the intentions claimed for euthanasia or PAS, this is nothing less than killing a patient.

- The ethical question remains – **can it ever be right to kill, even with the intention to relieve suffering?** The law of most countries is clear on this. To kill a patient, even with the intent to relieve suffering, is considered homicide. For this reason euthanasia is illegal in Canada and in most countries worldwide. Currently, only the Netherlands and Belgium have legalized euthanasia. PAS is also legal in the Netherlands and in Oregon, USA. Switzerland has legalized assisted suicide, even if performed by a non-physician.
- **Euthanasia, once legalized, would result in patients being killed who had not requested to die.** The experience of the Netherlands in legalizing euthanasia points to the fact that euthanasia, once legalized, cannot be effectively controlled. Euthanasia, initially intended for certain groups such as patients with terminal diseases will soon be performed on other groups of patients including the elderly, incapacitated patients, patients suffering with emotional distress, the disabled, and even children and newborn babies with disabilities who cannot ask for euthanasia. There is clear evidence from the Netherlands that at least **one thousand patients including children and newborn babies are being killed every year without their expressed consent and/or against their will.**

2. Sanctity or inviolability of life

- **Human life has an intrinsic value.** The Judaeo-Christian tradition holds that man is created in the image of God and therefore human life has an intrinsic dignity, sanctity and is inviolable. In that tradition, the principle that one should never kill an innocent human being is based on this very dignity and sanctity. From a non-religious point of view this principle would be based on the dignity and inviolability of human life, independent from the existence of God.
- The **Hippocratic Oath** affirms this same principle, not to prescribe a deadly drug and not to give advice causing death nor to procure an abortion. Hippocrates, a Greek physician lived in the fifth century BC and the principle of sanctity of life therefore predates Christian teaching. The **Declaration of Geneva** by the World Medical Association (1948) states: *'I will maintain the utmost respect for human life from its beginning'*. The 'right to life' has been included in the **Canadian Charter of Rights and Freedoms**. The same principle is also enshrined in the **European Convention on Human Rights**, which states: *'Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally...'*
- **The principle of sanctity or inviolability of life prohibits intentional killing but it does not require that life must be preserved at all cost**, for example through invasive or burdensome treatment, such as ventilation, against the wishes of a competent patient or where treatment would be futile, for example aggressive chemotherapy in advanced metastatic cancer. Doctors may have to decide whether a given treatment is proportionate or burdensome and disproportionate. The doctor will find it usually possible to make a correct judgment as to the means used in treatment by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources. Refusal of burdensome treatment on the part of the patient is not equivalent to suicide.

- Intentionally hastening a person's death by omitting some medical interventions – **'passive euthanasia'** – **is entirely different from omitting disproportionate or futile treatment.** The act of withholding or withdrawing disproportionate treatments (because they are disproportionate or futile) is different from the act of omitting proportionate treatment with the 'active' intention to hasten death. **The difference from euthanasia remains that if one accepts the principle of sanctity or inviolability of life, that the patient's life is always considered worthwhile** however the *treatment may not always be considered worthwhile.*

3. Patient autonomy will decrease once euthanasia or PAS has been legalized.

Despite all the claims made about 'patient autonomy' by proponents of euthanasia, ultimately, one or more doctors will inevitably end up making a value judgment, which they should not make, as to whether a patient's quality of life is such as to preserve or terminate his or her life.

- **If euthanasia became legalized, the decision whether to terminate or preserve a patient's life or to assist with PAS will rest with the medical profession.** To legalize euthanasia and PAS would dramatically *increase* the power doctors have over their patients and severely *decrease patient autonomy.*
- The German physician Christoph William Hufeland wrote in 1806: *'It is not up to [the doctor] whether life is happy or unhappy, worth while or not, and should he incorporate these perspectives into his trade the doctor could well become the most dangerous person in the state.'* (quoted in WJ Smith. Forced exit. Spence Publishing, Dallas 2003. p84.)

4. We are convinced that the following would happen if euthanasia became legalized:

4.1 Euthanasia, once legalized, could not be effectively controlled. If euthanasia became legal, patients would be killed who had not requested to die.

- Euthanasia, initially intended for certain groups such as patients with terminal diseases will sooner or later be performed on other groups of patients including the elderly, incapacitated patients, patients suffering with emotional distress, the disabled, and even children and newborn babies with disabilities. A change in legislation will lead to further devaluing of human life, especially for the vulnerable members of society. ***'Euthanasia, once accepted, is uncontrollable for philosophical, logical and practical reasons. Patients will certainly die without and against their wishes if any such legislation is introduced.'*** (Statement by the UK Association for Palliative Medicine & the National Council for Hospice and Specialist Palliative Care Services on proposals to legalize euthanasia and PAS. 2003)
- **Three surveys done over a 10-year period by Dutch researchers show that in Holland, where euthanasia has been legalized, at least 1,000 patients are killed every year through euthanasia without consent or without request. This constitutes murder.** The first report, published in 1991 showed that in 1,000 cases (equivalent to 0.8% of all deaths) physicians administered a drug with the explicit purpose of hastening the end of life without an explicit request by the patient. Two further reports from 1996 and 2001 confirm these findings. In 2001, still 1000 deaths (0.7% of total) were due to patients killed against their wishes or without explicit consent. (Van der Maas PJ et al.: Euthanasia and other medical decisions concerning the end of life. Lancet 1991; 338: 669-74. Van der Maas PJ et al.: Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990-1995. NEJM 1996; 335: 1699-705. Onwuteaka-Philipsen BJ et al.: Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995, and 2001. Lancet online 17 June 2003. <http://image.thelancet.com/extras/03art3297web.pdf>)
- **Dutch doctors currently only report half of all cases of euthanasia to the authorities. With such a low rate of reporting, Dutch claims of adequate control ring hollow.** In a recent analysis, the notification rate increased from 18% in 1990 to 45% in 1995 to 54% in 2001. Asked why doctors did not report cases of euthanasia to the authorities – even though they were required to do so by law – doctors responded that this requirement was considered burdensome and time consuming. More worrying obviously would be the

possibility that patients had been ‘euthanised’ by doctors in violation of the regulations and the cases were not reported in order to avoid criminal prosecutions. (Onwuteaka-Philipsen, BD et al. Dutch experience of monitoring euthanasia. British Medical Journal 2005; 331: 691–3)

- The ‘**slippery slope**’ is shown by what happens in Holland and in Belgium: **‘Dutch doctors have gone from killing the terminally ill who asked for it, to killing the chronically ill who ask for it, to killing the depressed who had no physical illness who ask for it, to killing newborn babies because they have birth defects, even though, by definition, they cannot ask for it.’** (Wesley J Smith. Forced exit. Dallas 2003. p 111.)
- Euthanasia does not stop with adults in the Netherlands. **9% of all neonatal deaths in the Netherlands occurred following the administration of drugs with the explicit aim of hastening death.** This was noted in two surveys in 1995 and 2001. **At least 2.7% of deaths of children between the ages of 1 and 17 in the Netherlands are due to euthanasia.** (Vrakking A et al. Medical end-of-life decisions made for neonates and infants in the Netherlands. 1995–2001. Lancet, 2005; 365: 1329-1331 Vrakking A et al. Medical end-of-life decisions for children in the Netherlands. Archives of Pediatrics & Adolescent Medicine 2005; 159: 802-9.)
- In Flanders, **Belgium, more than half of all neonatal deaths were due to doctors making ‘end of life decisions’, usually stopping the treatment of babies.** However, **7% of all neonatal deaths were due to injection with a lethal dose of medication.** Most of the babies had severe congenital malformations and/or were premature. $\frac{3}{4}$ of all neonatal physicians were prepared to engage in ‘euthanasia’ of newborn babies. (Provoost V. et al Medical end-of-life decisions in neonates and infants in Flanders. Lancet 2005; 365: 1315–20.) In 2002, Belgium legalized euthanasia for adults who are suffering ‘constant and unbearable physical or psychological pain’, and who are sufficiently conscious to make the request to die. To kill babies is illegal in Belgium. (Daily Telegraph; April 9th, 2005)

4.2 To legalize euthanasia or PAS would put immense pressure on those who are ill and especially those who feel that – due to illness, disability or due to expensive treatment required – they have become a burden to others and to society, especially to relatives.

- This is shown by the following case example from Holland: A 65 year old woman, suffering from incurable cancer, was discharged from hospital. Her doctor discussed euthanasia with her. The patient objected to euthanasia on religious grounds. However, with progressing cancer, she became more ill and considered herself a burden to her husband. She requested euthanasia and died. The case is reported and the public prosecutor couldn’t see anything wrong. (Dr Peter Hilderling, President, Dutch Physicians League in a presentation given at the House of Lords, London, UK, May 7th, 2003)
- In a study of terminally ill patients **those patients with substantial care needs** were more likely to feel being an economic burden to others. This group was **more likely to consider euthanasia or PAS.** (Emanuel EJ et al. Understanding economic and other burdens of terminal illness: the experience of patients and their caregivers. Annals of Internal Medicine. 2000; 132: 451-9.)
- In Oregon, physician-assisted suicide (PAS) was legalized in 1997. A recent survey found that, **with the increasing acceptance of PAS, the percentage of patients who died through PAS because they felt a burden to others** (not necessarily the only reason, however) **increased from 12% in 1998 to 26% in 1999 and to 63% in 2000.** (Sullivan AD et al. Legalized physician-assisted suicide in Oregon, 1998-2000. New England Journal of Medicine 2001; 344: 605-607.) When Oregon legalized PAS, only a minority of patients requested PAS because they felt a burden to others. However, with the increasing acceptance of PAS, nearly two-thirds of those dying through PAS cite being a burden to family, friends or caregivers as one of the main reasons for requesting PAS.

4.3 To legalize euthanasia or PAS would bring about profound changes in social attitudes to illness, disability, death, old age and the role of the medical profession. Once euthanasia is legalized, euthanasia will become increasingly an accepted ‘treatment option’ alongside the currently standard medical or surgical treatment.

- **With increasing acceptance of euthanasia, anyone with a medical condition – not just a terminal one – may consider euthanasia as a ‘treatment option’.** Euthanasia then would become an acceptable treatment option for conditions such as depression, stress, loneliness, fear of impending disease or fear of decline, but also for disabled children or adults. Euthanasia would become part of the armamentarium of medical treatment alongside established medical treatments such as pain relief, antidepressant medication, radiotherapy and chemotherapy.
- Dr Karel Gunning, a Dutch General Practitioner states: *“Once you accept killing as a solution for a single problem, you will find tomorrow hundreds of problems for which killing can be seen as a solution.”*
- The profound changes in social attitudes can be compared to the changes that occurred after the criminal code sanctions against abortion were removed as being unconstitutional. **As abortion is now an option for any woman who finds herself pregnant, euthanasia or PAS, once legal, will become an option for anyone who is (or considers himself/herself to be) ill.** After abortion was legalized in Canada in 1969, the first year in which statistics were available, 1970, 11,152 abortions were performed. In 2002, 105,154 abortions were performed. This startling increase indicates a profound loss of respect for the sanctity (or inviolability) of human life. Once the law permits the taking of human life the stage is set for the destruction of all vulnerable human life because the law serves as a guideline to the conscience. What is legal then becomes perceived to be morally permissible.

4.4 To legalize euthanasia and PAS will ultimately undermine medical care, especially palliative care and seriously undermined the doctor-patient relationship. It is claimed that euthanasia is about the ‘right to die’ a good death. However, euthanasia is not about the ‘right to die’. It is about giving doctors the right to kill their patients. We as physicians refuse to become the executioners of our patients.

- Legalizing euthanasia would mark a fundamental change in doctor-patient relationship where **patients will have to wonder whether ...’the physician coming into my hospital room is wearing the white coat of the healer ... or the black hood of the executioner.’** (British Medical Association statement – End of life decisions, 2000).
- The change in attitude among doctors who participate in euthanasia is graphically illustrated by the following conversation between Lord McColl, a professor of surgery, and a Dutch doctor about **what it was like doing the first case of euthanasia.** ‘Oh,’ he said, ‘we agonized all day. It was terrible. *However,* he said *the second case was much easier, and the third - I quote – ‘was a piece of cake’.* (Lord McColl in a speech in the House of Lords, UK; Lords Hansard, October 10th, 2005.)
- **It is easier and cheaper to kill a patient than to treat.** We have serious concerns about the provision of adequate palliative care services if euthanasia were legalized. We believe that euthanasia and PAS would undermine the efforts of good palliative care and the immense progress that has been made in palliative medicine in alleviating distressing symptoms and pain in dying patients. In the Netherlands, 84 % of those requesting euthanasia are in pain, and 70 % have difficulty breathing. A report on end-of-life care in the US found that less than 20 per cent of Oregon hospitals had palliative care programs, and it gave Oregon a Grade E for end-of-life care. (Baroness Finlay, Professor of Palliative Care in a debate in the House of Lords, Hansard; Oct. 10th, 2005, column 23f)

5. The ‘wish to die’ is rarely a truly autonomous decision.

The wish to die is more often an expression of depression, pain or poor symptom control rather than a genuine wish to die. The desire to die and the will to live frequently changes over time, especially if pain and depression have been treated.

- In Oregon, where PAS has been legalized, **nearly one in two patients who initially requested physician-assisted suicide (PAS) changed their mind after initiation of treatment, such as pain control, prescription of antidepressant medication or a referral to a hospice.** However, among those patients,

where no active symptom control was initiated, only 15% of those who initially requested physician-assisted suicide changed their mind. (Ganzini L et al. Physicians' experiences with the Oregon Death with Dignity Act. *New England Journal of Medicine* 2000; 342: 557-63.)

- In a survey of terminally ill patients, a total of 60% supported euthanasia in a hypothetical situation, however only 10.6% reported seriously considering euthanasia or PAS for themselves. Factors associated with being less likely to request euthanasia were feeling appreciated, factors associated with being more likely to request euthanasia were depression, significant care needs and pain. At follow-up interview **two to six months later, half of all terminally ill patients who had considered euthanasia or PAS for themselves changed their minds**, while an almost equal number began considering these interventions. (Emanuel EJ et al. Attitudes and desires related to euthanasia and physician-assisted suicide among terminally ill patients and their caregivers. *JAMA* 2000; 284: 2460-8.)
- Among terminally ill patients occasional wishes that death would come soon were common in nearly half of all patients but only 9% of these individuals acknowledged a serious desire to die. The desire for death was strongest in those with severe pain and low family support but most significantly in those with severe depression. **Nearly 60% of those patients who expressed a desire to die were depressed whereas depression was found in only 8% of patients without such a desire.** The authors conclude: *'The desire for death in terminally ill patients is closely associated with clinical depression – a potentially treatable condition – and can also decrease over time. Informed debate about euthanasia should recognize the importance of psychiatric considerations, as well as the inherent transience of many patients' expressed desire to die'*. (Chochinov HM et al. Desire for death in the terminally ill. *American Journal of Psychiatry*. 1995; 152: 1185-91)

6. Euthanasia and physician-assisted suicide – not the 'good death' hoped for.

One of the main arguments in favour of euthanasia and PAS is that it gives patients the chance of dying a 'good death'. However, the reality is very different. Dutch research shows that very distressing complications occur not infrequently when euthanasia and PAS are carried out. Rather than dying quickly, some patients took several days to die.

- Even though Dutch doctors have the longest experience with euthanasia of any country in the world, still distressing 'side effects' occur: In 18% of cases where a patient attempted physician-assisted suicide the doctor had to intervene and kill the patient. The reasons for this were that the patient awoke from coma, or had difficulty taking all the oral medication, vomited after taking the first medication or fell asleep before taking all the medication. Furthermore, in nearly half of the cases which started as PAS the patient did not die quickly enough and the doctor had to terminate the patient. **While it was planned for the patient to die within half an hour after taking the lethal drugs, 19% of patients took 45 minutes to seven days to die.** (Groenewoud JH et al. Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands. *New England Journal of Medicine* 2000; 342: 551-6.)
- There were fewer problems observed in euthanasia as opposed to PAS but still **10% of patients took much longer to die, some up to seven days.** In both euthanasia and physician-assisted suicide a small number of patients awoke from coma and had to be terminated. This certainly is not the 'good death' people hope for. (Groenewoud JH et al. *New England Journal of Medicine* 2000; 342: 551-6.)

7. Conclusion

While euthanasia and physician-assisted suicide (PAS) may superficially appear attractive, they have profound adverse effects on the social fabric of our society, on our attitude towards death and illness and on our attitude towards those who are ill or have disabilities.

Euthanasia, once legalized, cannot be adequately controlled. The Dutch experience shows, that around 1,000 patients are killed every year against their wishes, or, without consent, by their doctors. Euthanasia, initially intended for a certain group – for example patients with terminal illness – will soon spread to other groups, to those who are ill or

may even only consider themselves to be ill, and even to newborn babies with disabilities.

Euthanasia and PAS place increasing pressure to agree to be killed on those who are elderly or sick or who consider themselves – due to disease, disability or expensive treatment – to be a burden to relatives or to society. The ‘right to die’ soon becomes the ‘duty to die’.

With increasing acceptance of euthanasia and PAS, there will be a change in perception of illness, death and medical treatment. The example of legalized abortion shows what happens. Every woman who finds herself pregnant now has to consider whether to continue with the pregnancy or to opt for an abortion. Similarly, once legalized, euthanasia or PAS will become a ‘treatment’ option for those who are diagnosed with any illness, not just a terminal one, and who consider themselves to be ill.

It is always cheaper (and quicker) to kill than to treat. To legalize euthanasia will undermine medical care and especially palliative care. Where euthanasia and PAS have been legalized (for example in the Netherlands or in Oregon) the provision of palliative care appears to be poor or inadequate.

To legalize euthanasia will adversely affect the doctor-patient relationship. Despite all possible legal safeguards, patients will be wondering whether the doctor is wearing the white coat of the healer or the black hood of the executioner. As physicians, we never want to become the executioners of our patients.

As physicians and lawyers we strongly oppose any attempts to legalize euthanasia or physician-assisted suicide.

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Some definitions. All definitions of euthanasia agree that euthanasia means shortening the patient's life usually based on the belief that the patient would be better off dead.

Euthanasia is the active, intentional termination of a patient's life by a doctor who thinks that death is of benefit to the patient.

Voluntary euthanasia is euthanasia at the request (or at least with the consent) of the patient.

Involuntary euthanasia is euthanasia carried out against the wishes of a competent person.

Non-voluntary euthanasia is euthanasia carried out on incompetent patients such as babies or patients with dementia.

Active euthanasia is the intentional taking of a patient's life by a doctor who thinks that death is of benefit to the patient.

Passive euthanasia is the intentional termination of a patient's life by omission, for example by withdrawing treatment.

Physician-assisted suicide (PAS) – is where a doctor helps the patient to take his or her own life. In the Netherlands, no distinct moral difference is being made between PAS and euthanasia. The practical difference may not be significant – there is little difference between a patient taking a lethal medication into his mouth and swallowing it and the doctor placing the lethal medication into the patient's mouth and the patient swallowing it.

Further Reading. **John Keown** Euthanasia, ethics and public policy. Cambridge University Press, 2002.

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